DEPARTMENT of HEALTH and HUMAN SERVICES

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Fiscal Year 2003

containing:
Special Requirements
Self-Determination
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Indian Health Service

Justification of Estimates for Appropriations Committees

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Indian Health Service

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Indian Health Service Philosophy

The Indian Health Service (IHS) has implemented the Indian Self-Determination and Education Assistance Act (ISDA), Public Law 93-638, as amended, in the spirit by which the Congress recognized the special legal relationship and the obligation of the United States to American Indian and Alaska Native peoples. In keeping with the concept of tribal sovereignty, the ISDA, as amended, builds upon IHS policy that maximizes opportunities for tribes to exercise their right to manage and operate IHS health programs, or portions thereof, under Title I and Title V, as well as those tribes who choose their health services to be provided directly by the IHS. The IHS recognized that tribal decisions to contract/compact or not to contract/compact are equal expressions of self-determination.

Title I Contracts and Title V Self-Governance Compacts

The IHS contracts/compacts with tribes and tribal organizations (T/TO) pursuant to the authority provided under Title I and Title V of the ISDA, as amended. This Act allows T/TO to enter into contracts/compacts with the Government to plan, conduct, and administer programs that are authorized under Section 102 of the Act. The IHS has been contracting with T/TO pursuant to the authority of P.L. 93-638 since its passage in 1975. Today, the IHS currently administers self-determination contracts under Title I and compacts authorized under Title V valued at more than $1 billion. Title V provides authorization to sign self-governance compacts for a specific number of tribes who meet certain criteria. Fifty-five compacts and seventy-four funding agreements have been negotiated to date with 275 tribes.

IHS and Tribally-Operated Service Unit and Medical Facilities (See Table)

The total dollars administered under ISDA contracts and compacts have nearly doubled in recent years and the scope of services managed and provided by tribal programs has also expanded greatly. Tribes have historically assumed control of community services first and then expanded into medical care. For example, the CHR program and community-based components of the alcohol programs have been almost 100 percent tribally operated. Tribally operated hospitals have now started to rise, and over 20 percent of the hospitals funded by IHS are managed by tribes. This trend is expanding their scope and is also reflected in the increasing number of ambulatory medical facilities now managed by tribes.

Self-Determination Implementation: Contract Support Cost Funding

Because the rate of T/TO entering into self-determination contracts and compacts has been steadily increasing, the demand for contract support cost (CSC) funding to support T/TO in their contracting/compacting has also increased. The CSC funding is authorized pursuant to Section 106(a)(2) of the ISDA. This funding has been used by T/TO to develop strong, stable tribal governments that have in turn enabled them to professionally manage their contracts/compacts and the corresponding services to their communities. Additionally, through the funding of CSC, the IHS has helped in the development of T/TO who are maturing and now achieving greater levels of self-sufficiency in all areas.

It is critical to point out that the requested increases for CSC are attributed to increased contracting and compacting by T/TO under both Title I and V of the ISDA, a stated goal of both the Congress and the IHS. The Agency has taken steps to ensure that funding provided is allowable, allocable, reasonable, and necessary. The T/TO have, of necessity, also borne some of the burdens of administrative streamlining. The IHS has, beginning in FY 1995, provided administrative shares of its budget to T/TO associated with their contracting and compacting activities.

IHS AND TRIBALLY OPERATED SERVICE UNITS AND MEDICAL FACILITIES*
BY TYPE AND AREA AS OF OCTOBER 1, 1999

AREA	SERVICE UNITS			HOSPITAL				HEALTH CENTERS				SCHOOL HEALTH CENTERS				HEALTH STATIONS			
	Total	IHS	Tribal	Total	IHS	Tribal		Total	IHS	Tribal		Total	IHS	Tribal		Total	IHS	Tribal	
						I	III			I	III			I	III			I	III
All Areas	153	66	87	49	36	2	11	219	58	101	60	7	4	1	2	293	44	70	179
Aberdeen	18	13	5	8	8	0	0	14	8	6	0	2	1	1	0	15	12	3	0
Alaska	9	0	9	7	0	0	7	24	0	4	20	0	0	0	0	170v	0	10v	160v
Albuquerque	8	7	1	5	5	0	0	12	9	3	0	1	1	0	0	7	7	0	0
Bemidji	13	3	10	2	2	0	0	26	2	15	9	0	0	0	0	13	2	7	4
Billings	8	6	2	3	3	0	0	9	6	0	3	0	0	0	0	6	3	0	3
California	27	0	27	0	0	0	0	35	0	32	3	0	0	0	0	20	0	17	3
Nashville	21	1	20	2	1	0	1	20	0	19	1	1	0	0	1	9	0	6	3
Navajo	8	8	0	6	6	0	0	7	7	0	0	1	1	0	0	14	14	0	0
Oklahoma	12	9	3	7	4	1	2	38	11	9	18	1	0	0	1	0	0	0	0
Phoenix	11	8	3	8	6	1	1	13	5	8	0	0	0	0	0	10	4	5	1
Portland	16	9	7	0	0	0	0	18	7	5	6	1	1	0	0	27	0	22	5
Tucson	2	2	0	1	1	0	0	3	3	0	0	0	0	0	0	2	2	0	0

* Health locations are excluded.
v Village Clinics
I - Tribally operated facilities under Title I, P.L. 93-638, Self-Determination Contracts
III - Tribally operated facilities under Title III, P.L. 93-638, Self-Governance Compacts